New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number:

## Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: Act 1179 Compliance - Hearing SERFF Tr Num: IADC-126564611 State: Arkansas

Aids - STM

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 45300

Closed

Sub-TOI: H16G.004 Short Term Co Tr Num: SSL HEARING AID State Status: Approved-Closed

RIDER STM

Filing Type: Form Reviewer(s): Rosalind Minor

Author: Shellie Howard Disposition Date: 05/17/2010
Date Submitted: 03/30/2010 Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## **General Information**

Project Name: Status of Filing in Domicile: Not Filed

Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type:

Submission Type: New Submission Group Market Size:

Overall Rate Impact: Group Market Type:

Filing Status Changed: 05/17/2010 Explanation for Other Group Market Type:

State Status Changed: 05/17/2010

Deemer Date: Created By: Shellie Howard

Submitted By: Shellie Howard Corresponding Filing Tracking Number: IADC-

126160130/IADC-126329616

Filing Description:

Hearing aid benefit rider to comply with Act 1179 and bulletin 7A-2009. Please see cover letter for additional details.

# **Company and Contact**

## **Filing Contact Information**

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number:

Shellie Howard, Forms Development & howards@iacusa.com

Compliance Specialist

2101 W. Peoria Ave 602-861-6070 [Phone]

Suite 100

Phoenix, AZ 85029-4925

Filing Company Information

Standard Security Life Insurance Company of CoCode: 69078 State of Domicile: New York

New York

485 Madison Avenue Group Code: 450 Company Type: Life and Health

New York, NY 10022-4141 Group Name: State ID Number:

(212) 355-4141 ext. [Phone] FEIN Number: 13-5679267

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## **Filing Fees**

Fee Required? Yes
Fee Amount: \$60.00
Retaliatory? No

Fee Explanation: \$20 per form

3 forms x \$20=\$60

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Standard Security Life Insurance Company of \$60.00 03/30/2010 35261427

New York

Standard Security Life Insurance Company of \$40.00 05/17/2010 36595183

New York

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number:

# **Correspondence Summary**

## **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	05/17/2010	05/17/2010

### **Amendments**

Schedule Schedule Item Name		Created By	Created On	<b>Date Submitted</b>			
		-					
Form	Application	Shellie Howard	05/17/2010	05/17/2010			
Form	Application	Shellie Howard	05/17/2010	05/17/2010			
Form	Policyholder Election Form	Shellie Howard	05/17/2010	05/17/2010			
Supporting	Application	Shellie Howard	05/17/2010	05/17/2010			
Document							
Filing Notes							

Subject	Note Type	Created By	Created On	Date Submitted
Update on AR filing	Note To Reviewer	Shellie Howard	04/22/2010	0 04/22/2010
Filing Fees	Note To Filer	Rosalind Minor	04/02/2010	0 04/02/2010

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number: /

# **Disposition**

Disposition Date: 05/17/2010

Implementation Date: Status: Approved-Closed

Comment:

As requested, the applications are being withdrawn and the election form is being approved.

Rate data does NOT apply to filing.

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number:

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document (revised)	Application	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	[Optional] Hearing Aid Rider	Approved-Closed	Yes
Form (revised)	Application	Withdrawn	Yes
Form	Application	Withdrawn	Yes
Form (revised)	Application	Withdrawn	Yes
Form	Application	Withdrawn	Yes
Form	Policyholder Election Form	Approved-Closed	Yes

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number: /

#### **Amendment Letter**

Submitted Date: 05/17/2010

#### **Comments:**

Good afternoon, this filing has been revised and we respectfully withdraw our request for approval for the following application forms:

SSL-STM-0310A-APP-AR & SSL-STM-0310-APP0-AR. I have added in lieu of modifying the applications a policyholder election form number SSL AEAR OPT ELC AR 0410, for a total of 2 forms submitted for approval. I am also sending an additional \$40.00 to make up the difference in the filing fee.

Thank you for your continued review of this filing.

Sincerely,

#### Shellie Howard

### **Changed Items:**

### Form Schedule Item Changes:

#### Form Schedule Item Changes:

Form	Form	Form	Action	Form	Previous	Replaced	Readability	Attachments
Number	Type	Name		Action	Filing #	Form #	Score	
				Other				
SSL-STM-	Application/	EApplication	Revised		IADC-	SSL-STM-		
0310A-APP	- nrollment				126160130	0109-APP		
AR	Form							
SSL-STM-	Application/	EApplication	Revised		IADC-	SSL-STM-		
0310-APP-	nrollment				126329616	0909-APP		
AR	Form							
SSL AEAR	Other	Policyholde	r Initial					SSL AEAR
OPT ELC		Election						OPT ELC AR
AR 0410		Form						0410 for filing
								042310.pdf

#### **Supporting Document Schedule Item Changes:**

Satisfied -Name: Application

Comment: Application SSL-STM-0909-APP approved 10/6/09 State Tracking #43669

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number:

Application SSL-STM-0109-APP approved 05/28/09 State Tracking #42460

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number: /

#### **Note To Reviewer**

#### Created By:

Shellie Howard on 04/22/2010 10:31 AM

**Last Edited By:** Rosalind Minor

Submitted On:

05/17/2010 03:26 PM

Subject:

Update on AR filing

#### **Comments:**

Good morning Rosalind, I am going to be sending updated forms in addition to those already indicated, and updating the application to make the hearing aid benefit rider a policyholder option. So the new form will be a policyholder option form, and at that time I will send in the appropriate fees. This would apply to all the filing I submitted for SSL, MNL, and IAIC, it's just going to take me a couple of days to update the forms. Your understanding and patience is very much appreciated, and if you would like to discuss on the phone please call me or give me your number and I can call you. My number here is 6022-861-6070.

Thank you,

Shellie Howard

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number: /

**Note To Filer** 

Created By:

Rosalind Minor on 04/02/2010 02:36 PM

**Last Edited By:** Rosalind Minor

Submitted On:

05/17/2010 03:26 PM

Subject:
Filing Fees
Comments:

Our filing fees under Rule 57 has been updated. Please review the General Instructions for ArkansasLH.

The new fee for this submission would be \$50.00 per form for a total of \$150.00. Please submit an additional \$90.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number: /

## Form Schedule

Lead Form Number: SSL STM HEARAIDAE AR 0310

Schedule Item Status	Form Number	Form Type	e Form Name	Action	Action Specific Data	Readability	Attachment
Closed		Amendmer		Initial			SSL STM HEARAIDAE AR 0310 (Optional Hearing Aid Rider)032910. pdf
Withdrawn 05/17/2010		Application Enrollment Form	/Application	Revised	Replaced Form #: SSL-STM-0109-APP Previous Filing #: IADC-126160130		
	SSL-STM- 0310-APP- AR		/Application	Revised	Replaced Form #: SSL-STM-0909-APP Previous Filing #: IADC-126329616		
Approved- Closed 05/17/2010	SSL AEAR OPT ELC AR 0410	Other	Policyholder Election Form	Initial			SSL AEAR OPT ELC AR 0410 for filing

042310.pdf

### STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

[485 Madison Avenue, New York, NY 10022]

# [OPTIONAL] HEARING AID BENEFIT RIDER FOR ARKANSAS RESIDENTS ONLY

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

If You are covered under the [optional] Hearing Aid Benefit Rider, and if specified as applicable on the Schedule of Benefits, the Certificate is amended as follows:

- A. SECTION II, COVERED EXPENSES, SECTION B, COVERED EXPENSES FOR TREATMENT, SERVICES OR SUPPLIES the following benefit is added:
  - [17.] Hearing Aids, not subject to the Deductible or Daily Deductible [or Copay], up to \$[1,400] per ear for each [three-year] period. The Hearing Aids must be dispensed by an individual properly licensed by the State of Arkansas.
- **B.** Under the section entitled **LIMITATIONS AND EXCLUSIONS** the following change is hereby made:

Item [#33] pertaining to routine hearing exams is amended by deleting the reference to "the purchase of hearing aids."

**C.** Under the section entitled **DEFINITIONS** the following definition is added:

Hearing Aid means an instrument or device, including repair and replacement parts, that:

- a) Is designed and offered for the purpose of aiding Covered Persons with or compensating for impaired hearing:
- b) Is worn in or on the body; and
- c) Is generally not useful to a person in the absence of a hearing impairment.

### **TERMINATION**

Coverage under this Rider will end on [the earliest of:]

- 1. the date coverage under the Policy ends[; or
- 2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2009] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Rachel Lipari President Adam C. Vandervoot Secretary

Alon Volent

# STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

[485 Madison Avenue, New York, NY 10022]

# POLICYHOLDER ELECTION FORM ARKANSAS RESIDENTS ONLY

As elected by the Policyholder, and in consideration of any applicable additional premium for each Arkansas resident Certificate holder for each benefit option selected, Covered Charges will include all or any of the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

[1.]	Accept	Reject	Hearing Aids (	Act 1179 of 2009/B	ulletin 7A-2009)	
As th	e Policyholder, w	e request that	you indicate above	whether you accep	ot or reject this optional benefit:	
Policy	yholder Name: _					
Signe	ed for the Policyh	older				
Name	Э		Title		Date	

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number:

## **Supporting Document Schedules**

Item Status: Status

Date:

Satisfied - Item: Flesch Certification Approved-Closed 05/17/2010

Comments:

**Attachment:** 

ARCertificate of ComplianceSTM033010.pdf

Item Status: Status

Date:

Satisfied - Item: Application Approved-Closed 05/17/2010

**Comments:** 

Application SSL-STM-0909-APP approved 10/6/09 State Tracking #43669 Application SSL-STM-0109-APP approved 05/28/09 State Tracking #42460

Item Status: Status

Date:

Satisfied - Item: 3rd Party Authorization Approved-Closed 05/17/2010

Comments:

**Attachment:** 

SSL Filing Authorization Letter 2010.pdf

Item Status: Status

Date:

Satisfied - Item: Cover Letter Approved-Closed 05/17/2010

Comments:

Attachment:

SSL STM(AR)filing letter 033010.pdf

# Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Standard Security Life Insurance Company of New York (SSL)

Form Number(s):
SSL STM HEARAIDAE AR 0310 SSL STM 0310A-APP-AR SSL STM 0310-APP-AR
I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.
Signature of Company Officer:
Alon Volent
Adam Vandervoort Name
Secretary Title



January 6, 2010

**RE:** Standard Security Life Insurance Company of New York

NAIC Company Number: 69078 NAIC Group Number: 0450

FEIN Number: 13-5679267

### **AUTHORIZATION STATEMENT**

Standard Security Life Insurance Company of New York ("SSLICNY") hereby authorizes IHC Health Solutions (Member of the IHC Group), to represent us in the submission of accident and health insurance Group and Individual Policy Forms, and related forms and rates, and to negotiate with the Department for their approval.

Sincerely,

Adam C. Vandervoort

Alon Volent

Secretary



2101 W Peoria Avenue #100 Phoenix, AZ 85029

March 30, 2010

Honorable Jay Bradford Insurance Commissioner State of Arkansas Arkansas Department of Insurance 1200 W. Third St. Little Rock, AR 72201-1904

RE: Standard Security Life Insurance Company of New York

NAIC Company Number: 69078 NAIC Group Number: 0450 FEIN Number: 13-5679267

**Group Short Term Medical Insurance Policy – SSL-STMP-1104** 

New Form:

SSL STM HEARAIDAE AR 0310 [Optional] Hearing Aid Benefit Rider

Revised Form:

SSL STM 0310 APP AR Application SSL STM 0310A APP AR Application

Dear Commissioner Bradford:

We are submitting for your review and approval, the above referenced out-of-state Group Policy forms on behalf of Standard Security Life Insurance Company of New York {SSL}. This filing is being made in order to comply with Bulletin 7A-2009 & Act 1179 of 2009 regarding the mandatory offering of hearing aids. The Hearing Aid Benefit Rider is a new form and will not replace any approved forms currently on file with the Department. The application form (SSL STM 0310A APP AR) was revised to reflect the new hearing aid option. This form will replace form #(SSL STM 0109 APP) approved 05/28/09 under State Tracking #42460, SERFF #IADC-126160130 and the application form (SSL STM 0310 APP AR), also revised to include the hearing aid benefit, will replace form #(SSL STM 0909 APP) approved 10/6/09 under State Tracking #43669, SERFF #IADC-126329616. We will list this rider on the Schedule of Benefits as applicable or not applicable, depending on the applicant's selection.

IHC has received authorization to file life, accident, and health forms on SSL's behalf. For your reference, we have enclosed the filing letter of authorization from SSL. Additionally, we have also included a Certification signed by an officer of SSL, in accordance with Rule and Regulation 19.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. We confirm that the forms meet the minimum required readability standards.

For any questions or if any additional information is needed, please contact me at (602)-861-6070, or by email: <a href="mailto:howards@iacusa.com">howards@iacusa.com</a>. Thank you for your prompt consideration of this filing.

Sincerely,

Shellie Howard

Shellie Howard Form Development & Compliance Specialist

New York

Company Tracking Number: SSL HEARING AID RIDER STM

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term

Product Name: Act 1179 Compliance - Hearing Aids - STM

Project Name/Number:

# **Superseded Schedule Items**

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/30/2010	Form	Application	05/17/2010	SSL-STM-0310A-APP-AR (ForFiling{033010}.pdf (Superceded)
03/30/2010	Form	Application	05/17/2010	SSL-STM-0310-APP-AR (ForFiling033010).pdf (Superceded)
03/30/2010	Supporting Document	Application	05/17/2010	SSL-STM-0310A-APP-AR (ForFiling{033010}.pdf (Superceded) SSL-STM-0310-APP-AR (ForFiling033010).pdf (Superceded)

		ANSWER THE FOLLOWING MEDICAL HISTOR	Y QUESTIONS:			
COMPLETE THE FOLLOWING TO INSURE YOURSELF:	COMPLETE THE FOLLOWING PLAN CHOICES:	Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be				
Applicant:	Coverage Effective Date:	deducted from any premium refund due.  1. Will there be any other group or individual ma	sion modical health incurance in force on the no	liav offactiva data?	= Voc = N	
Last Name	□ Day after US Post Office Date	2. Is the proposed insured, spouse, or any depe	ndent child now pregnant?	ilcy effective date?	□ Yes □ N	
First Name	Stamp  □ Later Effective Date:	3. Have you or any person applying for coverage	e been declined for health insurance for a cond	lition that is still present?	□ Yes □ N	
Date of Birth Age Sex	● No more than [60] days in	4. Are you or any person applying for coverage	currently eligible for Medicaid?	01 nounds if female?	Yes □ N	
Social Security Number	advance]	2. Is the proposed insured, spouse, or any depe 3. Have you or any person applying for coverage 4. Are you or any person applying for coverage [5. Are you or any person applying for coverage [6.] Within the past [5] years have you or any person applying for coverage	erson applying for coverage been aware of, recommedical profession, taken medication for or ha	eived an abnormal test report for, be	en diagnosed with, been treated by or	
Occupation	Coverage Length:					
Telephone	□ Single Payment: Specify number of	■ heart disorder, heart attack, coronary	<ul> <li>paraplegia, quadriplegia or multiple</li> </ul>	■ kidney disorder other than stones	into al alto o	
Street Address		artery disease, coronary bypass or stent  peripheral vascular disease or carotid	sclerosis stem cell transplant	<ul> <li>degenerative disc disease or hernic</li> <li>rheumatoid or psoriatic arthritis</li> </ul>	ated disc	
	days (minimum [30] days,	artery disease	■ emphysema or COPD (chronic obstructive	■ degenerative joint disease of the kr		
City State Zip	maximum [365] days) or	stroke or other neurological disorder	pulmonary disease)	alcohol or drug abuse or dependent	ıcy	
Billing Address (if different)	□ Monthly Payment:	■ cancer or tumor	■ diabetes ■ liver disorder	■ hemophilia		
billing Address (il dillerent)			-		Pes □ No	
	□ Up to [12] Months]	[7.] Have you or any person proposed for cove or any other immune system disorder? Answ	erage been diagnosed or treated for Acquired II	mmune Deficiency Syndrome (AIDS)	), AIDS-related complex,	
City State Zip		or any other immune system disorder? Answ [[8.]Has any person proposed for coverage not	wer this question "no" if you have tested positive theen a legal resident of the United States for	e for HIV but nave not developed sy the last [12] consecutive months?	mptoms of the disease AIDS Yes Yes	
E-mail address	□ [Secure] STM Plan Coinsurance:	([NOTE: IF "YES IS	S ANSWERED ON ANY QUESTION 1 THROUGH [8	B], COVERAGE CANNOT BE ISSUED].)	)	
	□ 80/20 of \$5,000 □ 50/50 of \$5,000	ACCEPTANCE AND ACKNOWLEDGEMENT:				
COMPLETE THE FOLLOWING TO INSURE	□ 80/20 of \$10,000 □ 50/50 of \$10,000		any person whose medical history changes prior to	the persons Effective Date, such that the	e person's answer would be "ves" to any of the	
YOUR SPOUSE AND/OR CHILDREN:	□ 100%]*	A. I agree that coverage will not become effective for Medical History questions in this application. If suc	ch person is the Applicant, coverage is automatically	declined for all persons included in this a	application.	
	*100% not available with \$250 or \$1,000	B. I hereby request coverage under the policy issued	I to the group policyholder. I agree to all terms of the If this application and upon whose explanation of ben	group policy if the coverage applied for b efits, limitations or exclusions we relied (	pecomes effective. (1) was acting as an independent contractor and	
Spouse:	Deductible:  Deductible:	C. I understand that the agent or broker who solicited not as an agent of the Insurance Company; (2) wa	is retained by me as my agent; and (3) has no right to	alter the application, bind or approve co	overage or alter any of the terms or conditions of	
Last Name		the policy.  D. I certify that (1) I have read this application; (2) all	of my (our) answers are within my (our) personal known	owledge: and (3) all of my (our) answers	are complete true and correct	
	□ \$2,500 □ \$5,000 □ \$10,000	F Lagree to immediately notify the insurer of any character.	anges in any of the information contained in this appl	ication which may occur prior to the Effec	ctive Date of coverage	
First Name Age Sex	□ \$25,000]	F. I understand that health insurance benefits are exc within [5] years of my application for coverage.	, ,	. ,		
		<ul> <li>G. I understand that cancellation of this coverage with</li> </ul>	hin the 10 Day Right to Return the Certificate provisi	on as stated in the Certificate of Insuranc	ce will result in a refund of premiums only. [Any	
Social Security Number		administrative fees or other fees that may apply w	rill not be refunded].			
Occupation		Signature of Applicant or (Legal Guardian):			_ Date:	
Child(ren)Name	Deductible:	Signature of Spouse:			Date:	
Date of Birth Age	□ \$250 □ \$500 □ \$750					
Social Security Number		Fraud Warning: Any person who knowingly presents quilty of a crime and may be subject to fines and confined to the confined are confined are confined to the confined are		enefit or knowingly presents false informa	ation in an application for insurance is	
Child(ren)Name		guilty of a crime and may be subject to lines and comin	nement in prison.			
Date of Birth Age	<ul> <li>□ Optional Supplemental Accident Benefit</li> </ul>					
Social Security Number	[Optional Coverage -					
Child(ren)Name	Hearing Alus					
Date of Birth Age	I □ Accept □ RejectI					
Social Security Number	[Method of Payment					
	☐ Check or Money Order☐ Credit Card					
	☐ Monthly Automatic Bank Withdrawal					
	_ monthly / later late Daint William and	1				

		ANSWER THE FOLLOWING MEDICAL HISTORY	Y QUESTIONS:		
COMPLETE THE FOLLOWING TO INSURE	COMPLETE THE FOLLOWING	Mindatana anta and ancinciana anna ha a anatarial a			
YOURSELF:	PLAN CHOICES:	Misstatements and omissions may be a material m	nisrepresentation and a basis for rescission of of the control of	coverage. In the event of rescission; (1) coverage will be I be denied; (4) if any claims have been paid, the amount	void as of the tof claims haid will be
Applicant:	Cavarage Effective Date:	deducted from any premium refund due.			•
Last Name	Coverage Effective Date:  Day after US Post Office Date	Will there be any other group or individual maj	jor medical health insurance in force on the pol	licy effective date?	□ Yes □ N
	Stamp	2. Are you or any person applying for coverage of	now pregnant? currently eligible for Medicaid?		□ Yes □ N
First Name	□ Later Effective Date:	[4. Are you or any person applying for coverage	currently over [300] pounds if male or over [25	0] pounds if female? eived an abnormal test report for, been diagnosed with, b	□ Yes □ N
Date of Birth Age Sex	No more than [60] days in	[5.] Within the past [5] years have you or any per	rson applying for coverage been aware of, rece	eived an abnormal test report for, been diagnosed with, b d a device surgically implanted or in place for:	een treated by or
Social Security Number	advance] Coverage Length:	received follow-up care with a member of the	medical profession, taken medication for or na	d a device surgically implanted or in place for:	$\neg$
Occupation	[□ Single Payment: Specify number of	■ heart disorder, heart attack, coronary	■ paraplegia, quadriplegia or multiple	■ kidney disorder other than stones	
Telephone	days of coverage	artery disease, coronary bypass or stent	sclerosis	■ degenerative disc disease or herniated disc	
Street Address		<ul> <li>peripheral vascular disease or carotid artery disease</li> </ul>	<ul> <li>stem cell transplant</li> <li>emphysema or COPD (chronic obstructive</li> </ul>	<ul> <li>rheumatoid or psoriatic arthritis</li> <li>degenerative joint disease of the knees or hips</li> </ul>	
	maximum [365] days) or	stroke or other neurological disorder	pulmonary disease)	■ alcohol or drug abuse or dependency	
City State Zip		■ cancer or tumor	■ insulin-dependent diabetes	■ hemophilia	
Billing Address (if different)	□ Up to [6] Months		■ liver disorder		
billing Address (if different)	□ Up to [12] Months]	[6.] Have you or any person proposed for cove	rage been diagnosed or treated for Acquired Ir	nmune Deficiency Syndrome (AIDS), AIDS-related comp	olex,
		or any other immune system disorder? Answ	ver this guestion "no" if you have tested positive	e for HIV but have not developed symptoms of the diseas	ise AIDS⊓ Yes ⊓ N
City State Zip		[[7.]Has any person proposed for coverage not (INOTE: IF "YES IS	been a legal resident of the United States for the ANSWERED ON ANY QUESTION 1 THROUGH 17	the last [12] consecutive months?	🗆 Yes 🗆 I
E-mail address	Coinsurance: [□ 80/20 of \$5,000 □ 50/50 of \$5,000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 00 12 iu 102 0 iu 110 1 12 iu 100 25].,	
	□ 80/20 of \$10,000 □ 50/50 of \$10,000	ACCEPTANCE AND ACKNOWLEDGEMENT:	any navon whose medical history changes prior to t	the persons Effective Date, such that the person's answer would	d be "vee" to any of the
COMPLETE THE FOLLOWING TO INSURE	□ 100%]*	Medical History questions in this application. If such	any person whose medical history changes prior to the person is the Applicant, coverage is automatically (	the persons Effective Date, such that the person's answer would declined for all persons included in this application.	a be yes to any or the
YOUR SPOUSE/DOMESTIC PARTNER	*100% not available with \$250 or \$1,000	B. I hereby request coverage under the policy issued	to the group policyholder. I agree to all terms of the	declined for all persons included in this application. group policy if the coverage applied for becomes effective. efits, limitations or exclusions we relied (1) was acting as an ind	lanandant contractor and
AND/OR CHILDREN:	Deductible]  Deductible:	not as an agent of the Insurance Company; (2) was	s retained by me as my agent; and (3) has no right to	o alter the application, bind or approve coverage or alter any of t	the terms or conditions of
Spouse/Domestic Partner:	[=\$250 = \$500 = \$1,000	the policy.	of my (our) answers are within my (our) personal known	owledge; and (3) all of my (our) answers are complete, true and	correct
Last Name	□ \$2.500 □ \$5.000 □ \$10.000	F Lagree to immediately notify the insurer of any cha	inges in any of the information contained in this appli	ication which may occur prior to the Effective Date of coverage	
First Name	□ \$25,000]	F. I understand that health insurance benefits are exc	cluded for pre-existing conditions and this coverage v	vill not pay benefits for a disease or physical condition that I now	v have or have had
Date of Birth Age Sex		G. I understand that cancellation of this coverage with	nin the 10 Day Right to Return the Certificate provision	on as stated in the Certificate of Insurance will result in a refund	of premiums only. [Any
Social Security Number		administrative fees or other fees that may apply wi	ill not be refunded].		
		Signature of Applicant or (Legal Guardian):		Date:	
Occupation	Deductible:	Signature of Spouse/Domestic Partner:			
Child(ren)Name	□ \$250 □ \$500 □ \$750				
Date of Birth Age		Fraud Warning: Any person who knowingly presents a quilty of a crime and may be subject to fines and confir	a false or fraudulent claim for payment of a loss or be	enefit or knowingly presents false information in an application for	or insurance is
Social Security Number		guilty of a crime and may be subject to lines and comin	iernent in prison.		
Child(ren)Name	_ \$500 _ \$1,0001				
Date of Birth Age	[Optional Coverage -				
Social Security Number	Hearing Aids				
Child(ren)Name	□ Accept □ Reject]				
Date of Birth Age	[Method of Payment				
Social Security Number	□ Check or Money Order				
Social Security Number	□ Credit Card				
	☐ Monthly Automatic Bank Withdrawal				

		ANSWER THE FOLLOWING MEDICAL HISTOR	Y QUESTIONS:		
COMPLETE THE FOLLOWING TO INSURE YOURSELF:	COMPLETE THE FOLLOWING PLAN CHOICES:	Effective Date; (2) all premiums paid will be refund	nisrepresentation and a basis for rescission of ded; (3) all claims that have been submitted wil	coverage. In the event of rescission; (1) coverage will be denied; (4) if any claims have been paid, the amo	I be void as of the punt of claims paid will be
Applicant:	Coverage Effective Date:	deducted from any premium refund due.	ior modical health incurance in force on the ne	olicy effective date?	□ Voc □ N
Last Name	□ Day after US Post Office Date	2. Is the proposed insured, spouse, or any depe	ndent child now pregnant?	dition that is still present?	
First Name	Stamp  Later Effective Date:	3. Have you or any person applying for coverage	e been declined for health insurance for a cond	dition that is still present?	🗆 Yes 🗆 N
Date of Birth Age Sex	No more than [60] days in	4. Are you or any person applying for coverage	currently eligible for Medicald?	io] pounds if female?	□ Yes □ N
Social Security Number	advance]	[6.] Within the past [5] years have you or any pe	rson applying for coverage been aware of, rec	eived an abnormal test report for, been diagnosed wit	h, been treated by or
Occupation		·		a d d d d d d d d d d d d d d d d d d d	
Telephone	□ Single Payment: Specify number of	■ heart disorder, heart attack, coronary	<ul> <li>paraplegia, quadriplegia or multiple sclerosis</li> </ul>	■ kidney disorder other than stones	
Street Address	days of coverage	artery disease, coronary bypass or stent  ■ peripheral vascular disease or carotid	scierosis stem cell transplant	<ul> <li>degenerative disc disease or herniated disc</li> <li>rheumatoid or psoriatic arthritis</li> </ul>	
	days (minimum [30] days,	artery disease	■ emphysema or COPD (chronic obstructive	■ degenerative joint disease of the knees or hips	
City State Zip	maximum [365] days) or	<ul> <li>stroke or other neurological disorder</li> <li>cancer or tumor</li> </ul>	pulmonary disease) ■ diabetes	■ alcohol or drug abuse or dependency ■ hemophilia	
Billing Address (if different)	□ Monthly Payment.	Cancer of turnor	■ liver disorder	■ петюрища	
					🗆 Yes 🗆 No
City State Zip	□ Up to [12] Months]	[/.] Have you or any person proposed for cove	rage been diagnosed or treated for Acquired li	mmune Deficiency Syndrome (AIDS), AIDS-related core for HIV but have not developed symptoms of the dis	omplex, sease AIDS □ Yes □ I
E-mail address State 2ip	□ [Secure] STM Plan	[[8.]Has any person proposed for coverage not	been a legal resident of the United States for	the last [12] consecutive months?	
E-IIIdii duuless	Coinsurance:	([NOTE: IF "YES IS	S ANSWERED ON ANY QUESTION 1 THROUGH [8	B], COVERAGE CANNOT BE ISSUED].)	
	[□ 80/20 of \$5,000 □ 50/50 of \$5,000	ACCEPTANCE AND ACKNOWLEDGEMENT:			
COMPLETE THE FOLLOWING TO INSURE	□ 80/20 of \$10,000 □ 50/50 of \$10,000	A. I agree that coverage will not become effective for	any person whose medical history changes prior to	the persons Effective Date, such that the person's answer w declined for all persons included in this application.	ould be "yes" to any of the
YOUR SPOUSE AND/OR CHILDREN:	□ 100%]* *100% not available with \$250 or \$1,000	B. I hereby request coverage under the policy issued.	to the group policyholder. I agree to all terms of the	group policy if the coverage applied for becomes effective	
_	Deductible]	C. I understand that the agent or broker who solicited	this application and upon whose explanation of ben	nefits, limitations or exclusions we relied (1) was acting as an oalter the application, bind or approve coverage or alter any	independent contractor and
Spouse:	Deductible:	the policy			
Last Name	[=\$250 = \$500 = \$1,000	D. I certify that (1) I have read this application; (2) all	of my (our) answers are within my (our) personal kn	owledge; and (3) all of my (our) answers are complete, true lication which may occur prior to the Effective Date of covera will not pay benefits for a disease or physical condition that I	and correct.
First Name	□ \$2,500 □ \$5,000 □ \$10,000 □ \$25,000]	F. I understand that health insurance benefits are exc	cluded for pre-existing conditions and this coverage	will not pay benefits for a disease or physical condition that I	nge. now have or have had
Date of Birth Age Sex	□ Ψ25,000]	I within 151 years of my application for coverage.		on as stated in the Certificate of Insurance will result in a ref	
Social Security Number	[□ Daily Deductible STM Plan	administrative fees or other fees that may apply w	ill not be refunded].	on as stated in the Certificate of insurance will result in a ref	und of premiums only. [Any
Occupation	Coinsurance:	Signature of Applicant or (Legal Guardian):		Date:	
Child(ren)Name	Deductible:				
Date of Birth Age	□ \$250 □ \$500 □ \$750	Signature of Spouse:			
Social Security Number	□ \$1,000J	Fraud Warning: Any person who knowingly presents guilty of a crime and may be subject to fines and confined and confined and confined and confined are confined as a crime and confined are crime and confined are crime as a crime and crime are crime as a crime are crime are crime as a crime are crime as a crime are crime are crime as a crime are crime as a crime are crime as a crime are crime are crime as a crime are crime as a crime are crime are crime are crime are crime as a crime are crime are crime are		enefit or knowingly presents false information in an application	on for insurance is
Child(ren)Name	[□ Optional Supplemental		·		
Child(ren)Name Age	Accident Benefit				
Social Security Number	□ \$500 □ \$1,000]			(	(SSL Secure STM APP 1-09
Child(ren)Name	[Optional Coverage -				
Child(ren)Name Age	Hearing Aids  □ Accept □ Reject]				
Social Security Number	[Method of Payment				
	☐ Check or Money Order				
	□ Credit Card	]			
	<ul> <li>Monthly Automatic Bank Withdrawal</li> </ul>				

		ANSWER THE FOLLOWING MEDICAL HISTOR	Y QUESTIONS:		
COMPLETE THE FOLLOWING TO INSURE	COMPLETE THE FOLLOWING				
YOURSELF:	PLAN CHOICES:	Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be			
Applicant:	Coverage Effective Date:	deducted from any premium refund due.			
Last Name		1. Will there be any other group or individual major medical health insurance in force on the policy effective date?			
	Stamp	3. Are you or any person applying for coverage now pregnant?			
First Name Age Sex	□ Later Effective Date:	3. Are you or any person applying for coverage currently eligible for Medicaid? Yes N  [4. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? Yes N  [5.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:			
		[5.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:			
Social Security Number	Cavarage Langiby	received follow-up care with a member of the	medical profession, taken medication for or na	d a device surgically implanted of in place for.	l
Occupation	[□ Single Payment: Specify number of	■ heart disorder, heart attack, coronary	<ul> <li>paraplegia, quadriplegia or multiple</li> </ul>	■ kidney disorder other than stones	1
Telephone	days of coverage	artery disease, coronary bypass or stent  ■ peripheral vascular disease or carotid	sclerosis ■ stem cell transplant	<ul> <li>■ degenerative disc disease or herniated disc</li> <li>■ rheumatoid or psoriatic arthritis</li> </ul>	1
Street Address		artery disease	■ emphysema or COPD (chronic obstructive	■ degenerative joint disease of the knees or hips	1
	maximum [365] days) or	stroke or other neurological disorder	pulmonary disease)	■ alcohol or drug abuse or dependency	1
City State Zip	□ Monthly Payment:	■ cancer or tumor	■ insulin-dependent diabetes ■ liver disorder	■ hemophilia	1
Billing Address (if different)				mmune Deficiency Syndrome (AIDS), AIDS-related complex	🗆 Yes 🗆 No
3	□ Up to [12] Months]	[6.] Have you or any person proposed for cove	rage been diagnosed or treated for Acquired I	mmune Deficiency Syndrome (AIDS), AIDS-related complex	, AIDO V
City State Zip	□ [Secure] STM Plan	17.1Has any person proposed for coverage not	ver this question no if you have tested positive been a legal resident of the United States for	re for HIV but have not developed symptoms of the disease A	NIDS□ Yes □ I
E-mail address State Zip		[[7.]Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months?			
E-IIIdii duuless	□ 80/20 of \$5,000 □ 50/50 of \$5,000	ACCEPTANCE AND ACKNOWLEDGEMENT:			
	□ 80/20 of \$10,000 □ 50/50 of \$10,000	JUI A. Lagree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the			
COMPLETE THE FOLLOWING TO INSURE	□ 100%]* *100% not available with \$250 or \$1,000	Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.			
YOUR SPOUSE/DOMESTIC PARTNER	Deductible]]	B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.  C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and			
AND/OR CHILDREN:	Deductible:	not as an agent of the Insurance Company; (2) was the policy.	s retained by me as my agent; and (3) has no right t	o alter the application, bind or approve coverage or alter any of the t	erms or conditions of
Spouse/Domestic Partner:	[=\$250 = \$500 = \$1,000	D   Legrify that (1) I have read this application: (2) all	of my (our) answers are within my (our) personal kn	owledge; and (3) all of my (our) answers are complete, true and corr	rect.
Last Name	□ \$2,500 □ \$5,000 □ \$10,000 □ \$25,000]	E. I agree to immediately notify the insurer of any cha	inges in any of the information contained in this applications and this coverage.	lication which may occur prior to the Effective Date of coverage. will not pay benefits for a disease or physical condition that I now ha	we or have had
First Name	□ \$25,000] -	within [5] years of my application for coverage.	stated for pre-existing conditions and this coverage	on as stated in the Certificate of Insurance will result in a refund of p	ve or nave nau
Date of Birth Age Sex		G. I understand that cancellation of this coverage with administrative fees or other fees that may apply with a second control of the coverage with a second cov	nin the 10 Day Right to Return the Certificate provisi	on as stated in the Certificate of Insurance will result in a refund of p	remiums only. [Any
Social Security Number	Coinsurance:			_	
Occupation	Not applicable	Signature of Applicant or (Legal Guardian):		Date:	
Child(ren)Name	<b>Deductible:</b> □ \$250 □ \$500 □ \$750	Signature of Spouse/Domestic Partner:		Date:	
Child(ren)Name Age	□ \$1,000]	Fraud Warning: Any person who knowingly presents a	a false or fraudulent claim for payment of a loss or b	enefit or knowingly presents false information in an application for in	isurance is
Social Security Number		guilty of a crime and may be subject to fines and confir		one of the one of the original original original original original original original original original origina	04.400 .0
Child(ren)Name	Accident Benefit				
Date of Birth Age	□ \$500 □ \$1,000]				
Social Socurity Number	[Optional Coverage - Hearing Aids				
Social Security Number	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
Child(ren)Name					
Date of Birth Age					
Social Security Number	☐ Check or Money Order☐ Credit Card				
	☐ Credit Card☐ Monthly Automatic Bank Withdrawal☐	1			
	- Monany Automatio Bank Withdrawai	1			
		1			